

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **ROBERT PAGE, M.D.**

4 Holder of License No. 7689
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Case No. MD-11-0578A

**ORDER FOR DECREE OF CENSURE
AND CONSENT TO THE SAME**

7 Robert Page, M.D. ("Respondent") elects to permanently waive any right to a
8 hearing and appeal with respect to this Order for Decree of Censure; admits the
9 jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order
10 by the Board.

11 **FINDINGS OF FACT**

12 1. The Board is the duly constituted authority for the regulation and control of
13 the practice of allopathic medicine in the State of Arizona.

14 2. Respondent is the holder of license number 7689 for the practice of
15 allopathic medicine in the State of Arizona.

16 3. The Board initiated case number MD-11-0578A after receiving notification
17 from Banner Desert Medical Center that Respondent agreed to refrain from practice
18 pending completion of further investigation regarding Respondent's care and treatment of
19 patient AG.

20 4. In the late evening of December 1, 2010, Respondent admitted AG to
21 Banner Desert Medical Center. AG's admitting diagnoses included cellulitis of the right
22 foot and ankle, an open wound on the sole of the right foot and severe stasis dermatitis of
23 both lower extremities complicating chronic problems of insulin dependent diabetes. AG
24 was morbidly obese and had hypertension. He had a history of congestive heart failure
25

1 with cardiomegaly, sleep apnea, renal insufficiency hyperlipidemia, peripheral neuropathy,
2 B-12 deficiency, and reflux.

3 5. Respondent saw AG in the afternoon of December 2, 2010, and focused on
4 cellulitis of the leg and the poorly controlled diabetes as the central issues. He did not
5 restart AF on his CPAP machine. Respondent did not order any additional tests over the
6 course of AG's stay beyond blood sugar checks. Respondent did not order consultations
7 on AG beyond podiatry for the foot wound, in spite of the poor urinalysis suggesting
8 severe kidney disease, the severely low albumin, or the ongoing problems with heart
9 failure in a morbidly obese patient. Over the next several days, AG had a total of 3,735 cc
10 of fluid intake with only 525 cc of output.

11 6. AG was given several IV diuretics over this almost three day period, but
12 there was no effect. No further studies, labs or consults were ordered during this time in
13 spite of the severely low output, the very low blood pressure, the waxing and waning of
14 oxygen saturations or the rapidly increasing weight.

15 7. In the early morning hours of December 4, 2010, AG was found
16 unresponsive, not breathing in cardiac arrest and a code was called. He was found to be
17 in asystole and pulseless. Within eight minutes of initiating the code, a heart rhythm was
18 regained, after which labs were drawn and AG was transported to ICU on a ventilator for
19 further management. Lab work revealed a worsening anemia, significant worsening of
20 renal function and worsening of the very low albumin. AG never regained consciousness.
21 In the evening of December 7, 2010, after further testing on AG's mental status and
22 progressive worsening of the renal function, with the consent of the family, AG was taken
23 off the ventilator and allowed to expire.

24 8. The standard of care for a hospitalized patient with multiple medical issues
25 including progressively worsening renal output in spite of diuretic administration and

1 weight gain requires a physician to consult nephrology regarding renal function, cardiology
2 regarding heart function, and possibly an endocrinologist regarding blood sugar.

3 9. Respondent deviated from the standard of care by failing to order any
4 consultations besides podiatry for wound care.

5 10. The standard of care for a patient being on three medications that affect
6 renal function requires a physician to obtain blood work to include renal function, blood
7 count, and heart failure labs.

8 11. Respondent deviated from the standard of care by failing to order any lab
9 work after AG's hospital admission on December 1, 2010.

10 12. The standard of care for a patient with sleep apnea requires a physician to
11 restart the patient's CPAP on entrance to the hospital.

12 13. Respondent deviated from the standard of care by failing to restart AG's
13 CPAP upon admission to the hospital.

14 14. Respondent's deviations from the standard of care may have contributed to
15 AG's development of acute renal failure during his initial three days in the hospital that
16 progressively worsened in spite of later treatment from December 4 – 7, 2010. The
17 record does not, however, contain sufficient evidence to establish that Respondent's
18 conduct actually caused or contributed to the patient's cardiac arrest and subsequent
19 death.

20 **CONCLUSIONS OF LAW**

21 1. The Board possesses jurisdiction over the subject matter hereof and over
22 Respondent.

23 2. The conduct and circumstances described above constitute unprofessional
24 conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be
25 harmful or dangerous to the health of the patient or the public.").

1
2 ORDER

3 IT IS HEREBY ORDERED THAT Respondent is issued a Decree of Censure.


4
5 DATED AND EFFECTIVE this 3rd day of Feb, 2011³.

6 ARIZONA MEDICAL BOARD

7 (SEAL)



By


Lisa S. Wynn
Executive Director

12 CONSENT TO ENTRY OF ORDER

13 1. Respondent has read and understands this Consent Agreement and the
14 stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent
15 acknowledges he has the right to consult with legal counsel regarding this matter.

16 2. Respondent acknowledges and agrees that this Order is entered into freely
17 and voluntarily and that no promise was made or coercion used to induce such entry.

18 3. By consenting to this Order, Respondent voluntarily relinquishes any rights
19 to a hearing or judicial review in state or federal court on the matters alleged, or to
20 challenge this Order in its entirety as issued by the Board, and waives any other cause of
21 action related thereto or arising from said Order.

22 4. The Order is not effective until approved by the Board and signed by its
23 Executive Director.

24 5. All admissions made by Respondent are solely for final disposition of this
25 matter and any subsequent related administrative proceedings or civil litigation involving
the Board and Respondent. Therefore, said admissions by Respondent are not intended

1 or made for any other use, such as in the context of another state or federal government
2 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or
3 any other state or federal court.

4 6. Upon signing this agreement, and returning this document (or a copy
5 thereof) to the Board's Executive Director, Respondent may not revoke the consent to the
6 entry of the Order. Respondent may not make any modifications to the document. Any
7 modifications to this original document are ineffective and void unless mutually approved
8 by the parties.

9 7. This Order is a public record that will be publicly disseminated as a formal
10 disciplinary action of the Board and will be reported to the National Practitioner's Data
11 Bank and on the Board's web site as a disciplinary action.

12 8. If any part of the Order is later declared void or otherwise unenforceable, the
13 remainder of the Order in its entirety shall remain in force and effect.

14 9. If the Board does not adopt this Order, Respondent will not assert as a
15 defense that the Board's consideration of the Order constitutes bias, prejudice,
16 prejudgment or other similar defense.

17 10. Any violation of this Order constitutes unprofessional conduct and may result
18 in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation,
19 consent agreement or stipulation issued or entered into by the board or its executive
20 director under this chapter") and 32-1451.

21 

22 Robert Page, M.D.

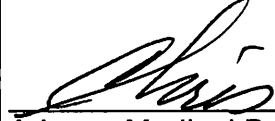
23 DATED: 12/17/11

24 EXECUTED COPY of the foregoing mailed
25 this 30 day of July, 2011 to:

1 Daniel Benchoff, Esq.
2 Rake Law Group, PC
3 2701 East Camelback Road, Suite 160
4 Phoenix, Arizona 85016-4326

5 ORIGINAL of the foregoing filed
6 this 30th day of Feb., 2011 with:

7 Arizona Medical Board
8 9545 E. Doubletree Ranch Road
9 Scottsdale, AZ 85258

10 

11 Arizona Medical Board Staff
12
13
14
15
16
17
18
19
20
21
22
23
24
25